

# SEX DIFFERENCES AND SYMPTOM PATTERNS IN EARLY CHILDHOOD

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Although a number of studies have been carried out on problems in children of school age (Ackerson, 1942; Gilbert, 1957; Griffiths, 1952; Jenkins and Glickman, 1946; Lapouse and Monk, 1958; Patterson, 1955), there are as yet few normative data in this area to aid the clinician in his evaluation of the preschool child. For adults, a variety of specific behavioral manifestations have become accepted as symptomatic of psychological disturbances (Wittenborn et al., 1953). By contrast, in the young child, similar manifestations may be no more than normal stress reactions. Although this viewpoint has been generally accepted, there are still very few normative data to aid the clinician in his decision as to when a behavior problem in the young child reflects phase-specific development stress and conflict, and when it points to a more serious disturbance in the child. A central objective of the present study has been to contribute relevant data in this area.

When we undertook the present investigation we had to face three major issues germane to this type of research: (a) source of information; (b) consistency in data collection; and (c) sampling. A brief discussion of these issues, we hope, will provide a better perspective for the scope of our study and our findings.

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*Source of Information*

Problems of the young child are often experienced more clearly by other people in his environment than by the child himself; that is, unlike the adult the child often does not suffer from the symptoms himself, but causes the environment to suffer. Moreover, the child cannot verbalize his problems. We therefore have to rely to a considerable extent on parents for a description and history of the child's problems. This makes it difficult to distinguish between "disturbing" and "disturbed" behavior of the child. The problems reported by the parent may reflect primarily the parent's own problems, as well. Thus, the validity and reliability of the parents' perception and report of symptoms in their child constitute issues in their own right (Glidwell et al., 1957; Wenar and Coulter, 1962).

*Consistency of Data Collection*

A major problem of subjecting clinical data to quantitative analysis has been that the procedures for obtaining such data are not consistent from case to case. Because of this inconsistency one cannot know whether variation among patients in a given area reflects a lack of uniformity in data gathering, or true variations among patients. It is, therefore, understandable that some researchers prefer standardized procedures so as to elicit information consistently from subject to subject. However, such an approach has its drawbacks from a clinical point of view. Standardized interviews do not permit relevant information to emerge in a context of reporting determined by the patient himself. Within the framework of clinical study, the interviewer is guided by the patient in his timing and formulation of questions, as well as in the detail of his inquiry.

In order to cope with the problem of unevenness of clinical data, the present study employed a special procedure. The clinical records at the Child Development Center were assessed in advance for their suitability as data for this and other research projects. In a study described in detail elsewhere (Beller, 1962), it was found that at least 90 per cent of these clinical records at the Center contained abundant information on the history of children's problems, reported by parents during intake and diagnostic study. This meant that we could be assured of considerable homogeneity in the amount of relevant data on

behavior problems among the clinical records of the Child Development Center.

### *Sampling*

Because of our interest in contributing data on the incidence of problems in early childhood, the size and representativeness of our sample was an important consideration in the planning of our study. Our decision to restrict our study to a clinical population in one clinical setting clearly limited in advance the usefulness of our research with regard to yielding normative findings. However, we felt that this limitation might be compensated for by the fact that we were more confident of working with a set of clinical data which met one of the basic prerequisites in quantitative research, that is, homogeneity in the amount of relevant data between the subjects in our sample.

These were three major issues which confronted us in the planning of our study. The basic objectives of the present study were (1) to classify psychosocial disturbances of the preschool child; (2) to analyze the frequency and distribution of these disturbances in a clinical population of children; and (3) to study the pattern of these problems, particularly in relation to sex differences.

### PROCEDURE

The study was carried out at the Child Development Center, a clinic for intensive study and treatment of psychological disturbances in early childhood. After completion of the preliminary assessment of clinical records described above, we proceeded to select cases for the substantive study. In our selection we excluded records of children with clear evidence of organic impairment or mental retardation. We also excluded cases for whom the diagnostic study was limited to one or two contacts or for whom the diagnostic summary was not available in the record. Furthermore, since we wanted to study sex differences, we selected an equal number of boys and girls by randomly excluding girls, who constituted the larger group in our clinical population.

The present study was based on diagnostic interviews with urban middle- and lower-middle-class parents of fifty-five boys and fifty-five girls. The large majority of the parents were Jewish and second-generation immigrants from Europe. About half of the parents had at

least some college education and the majority of fathers fell into the two highest professional categories (see Table 1). All but three of the children came from intact homes. Two boys and two girls were adopted children. Further relevant characteristics of these children and their parents have been summarized in Table 1.

Several interesting facts emerge upon closer scrutiny of the summary in Table 1. Although the age difference between boys and girls is a small one, it is statistically significant ( $t=3.06$ ,  $df=108$ ,  $p < .01$ ). Thus, it appears that parents tend to seek professional help somewhat earlier for girls than for boys. Two thirds of the children brought to this clinic were first-borns. It is also noteworthy that these parents who sought help for their children appear to be considerably older than the average parent of a three-year-old child. Unfortunately we could get only somewhat comparable normative data, that is, the age of 50,790 white mothers at the birth of their first child and 47,018 white mothers at the birth of their second child in New York City during the year 1952. A comparison with comparable groups of 75 and 34 mothers in our sample revealed that our mothers were approximately six years older and that this difference was statistically highly significant ( $t=10.62$  and  $t=6.65$ ). Although we did not investigate the implications of parental age and the child's sibling status in the present study, it is evident from the above that these factors deserve special attention in further research on clinical populations of children.

As indicated earlier, information on behavior problems and symptoms was extracted from clinical records of diagnostic interviews and summaries. These problems were classified in twenty-five different categories. Percentage agreement between coders for these classifications ranged from 70 to 95 per cent. Examples of statements by parents classified in each of these categories are presented in the Appendix.

## RESULTS AND DISCUSSION

### *Frequency of Problems*

The first step in our analysis consisted in determining the frequency (percentage) of children who had each of the problems selected for study. Inspection of Table 2 shows that children's disturbances in feeding and in sleep constituted the largest share of early difficulties. As might be expected, problems in the mother-child relationship often revolved around feeding. The relatively high incidence of fears and

TABLE 1  
Characteristics of Sample: Age, Sibling Status, Education and Professions

AGE IN MONTHS			SIBLING STATUS			
N	Mean	SD	N	Only	Oldest	Youngest
Boys	55	39.9	13.1	55	32.7%	30.9%
Girls	55	37.7	10.5	55	32.7%	27.3%
					38.2%	1.8%

  

AGE IN YEARS			EDUCATION			
N†	Mean	SD	N†	Elementary/ High School	High School Graduate	Some College
Fathers	109	38.6	5.5	97	13.4%	16.5%
Mothers	110	34.8	5.5	97	8.2%	32.0%
						16.5%
						21.6%
						38.1%
						26.8%
						15.5%
						11.3%

  

FATHERS' PROFESSIONS* (N=97) †				
I	II	III		
Professional, Technical	Managers, Officials, Proprietors	Clerical, Sales	Craftsmen, Fore- men, Operators	Service Workers
32.0%	23.7%	27.8%	12.4%	2.1%
				2.1%

† Variation in the N of parents is due to one deceased father, and the presence of eleven pairs and one triad of siblings among our children.

\* Categories of classification correspond to those used in the 1960 Census of Population on Social and Economic Characteristics, U.S. Government Printing Office, Washington, D. C.

\*\* Deceased or unemployed.

aggression problems could also be expected in our group of emotionally disturbed children. However, we did not anticipate such high incidence of sleep disturbances. Similarly, the low incidence in our clinical sample of bladder and bowel control problems, as well as of autoerotic manifestations such as thumb sucking and masturbation was somewhat surprising.

TABLE 2  
Percentages of 110 Children with Each of 25 Problems  
Based on 55 Boys and 55 Girls

<i>Problems</i>	<i>Boys</i>	<i>Girls</i>	<i>Total</i>
1. Feeding	.71	.75	.73
2. Sleeping	.64	.67	.65
3. Fears	.51	.58	.55
4. Aggression	.64	.40	.52
5. Temper tantrums	.38	.33	.35
6. Overdependency	.25	.45	.35
7. Bladder control	.36	.35	.35
8. Speech	.42	.24	.33
9. Defiance	.35	.31	.33
10. Frustration tolerance	.36	.25	.31
11. Thumb sucking	.25	.36	.31
12. Sibling rivalry*	.19	.43	.31
13. Bowel	.31	.27	.29
14. Compulsivity	.25	.33	.29
15. Separation anxiety	.22	.31	.26
16. Hyperactivity	.31	.15	.23
17. Regression	.18	.22	.20
18. Toilet: General	.16	.18	.17
19. Emotional overcontrol	.09	.27	.17
20. Masturbation	.16	.18	.17
21. Imaginary figure	.15	.09	.12
22. Sex identification	.04	.05	.05
23. Nail biting	.07	0	.04
24. Tics	.04	.02	.03
25. Drooling	.02	0	.01

\* Based on 37 girls and 37 boys with siblings.

The literature suggests that the low incidence of reported toilet problems and autoerotic manifestations may be, in part, the result of changes in child-rearing attitudes and practices. For example, Wolfenstein (1953) who studied successive editions of the United States Children's Bureau Bulletin of Infant Care between 1914 and 1951, noticed a shift of recommendations from strictness in training to

advocating mildness in areas of thumb sucking, weaning, toilet training, and masturbation. In a more recent study of trends in child-rearing practices over the last twenty-five years, Bronfenbrenner (1958) concluded that American mothers are becoming increasingly permissive in feeding and toilet-training practices during the first two years of the child's life. Thus, changes in the general population extend to our clinical sample, particularly with regard to fewer reports of disturbances in toilet training and autoerotic manifestations. However, the trend toward greater permissiveness in feeding practices, reported by these studies, has not resulted in a relative decrease of feeding problems in our group of disturbed children.

### *Sex Differences*

Let us now turn to findings of sex differences in relation to symptoms. As can be seen from Table 3, parents reported significantly<sup>1</sup> more aggression, hyperactivity, lack of bowel control, and speech disturbances in boys. For girls, parents reported significantly more problems of overdependence, of emotional overcontrol, of bowel retention, and of sibling rivalry.

TABLE 3  
Chi-square Tests of Sex Differences in the Incidence of  
Problems in 55 Boys and 55 Girls

	$\chi^2$ *	$p$
More Frequent in Boys		
Aggression	5.24	<.05
Hyperactivity	3.31	<.10
Lack of bowel control	4.45	<.05
Speech disturbance	3.34	<.10
More Frequent in Girls		
Overdependency	3.97	<.05
Emotional overcontrol	4.95	<.05
Bowel retention	4.58	<.05
Sibling rivalry	4.04	<.05

\*  $df=1$ , corrected for continuity.

It is interesting to note that more than half of these sex differences in our clinical sample were in accord with normative findings in the

<sup>1</sup> Since this is an exploratory study, we have accepted  $p < .10$  as a criterion for significance.

research literature.<sup>2</sup> Other studies of clinical and nonclinical populations have also reported that boys are more aggressive, more active, and slower in speech development, while girls tend to be more dependent and more jealous (Anastasi and Foley, 1949; Beller and Turner, 1962; Gilbert, 1957; McFarlane et al., 1954; Olson, 1949; Terman and Tyler, 1954). We have not come across enough comparable findings in the literature to evaluate normatively the other sex differences that we found in our clinical sample.

### *Symptom Patterning*

Only a relatively few relationships between symptoms applied to the whole group without being sex linked.<sup>3</sup> The vast majority of significant relationships were found in one or the other sex but did not emerge equally in both. We shall therefore discuss separately symptom patterning in boys and in girls.

The sex differences presented earlier (Table 3) become more meaningful when we consider them in the light of symptom patterns (see Table 4). For example, aggression occurred more often in boys, and correlated, only in boys, with temper tantrums. Tantrums in turn correlated, only in boys, with slow toilet training. Thus, what emerges is a suggestion that a difficulty in impulse control is at the basis of these interrelated problems in boys. This picture gains still further meaning when we study the role of defiance in this symptom pattern. Defiance correlated, only in boys, with aggression, hyperactivity, and sleep disturbance. This suggests that these male children not only have difficulty in impulse control, but actively resist or defy the mother's demand for compliance.

The next finding was that defiant boys failed to manifest separation anxiety (see Table 4). This suggested that lack of impulse control found in defiant boys may also be associated with an absence of early intensive ties to the mother. This relationship was tested subsequently

<sup>2</sup> Since a relatively small age difference, that is, boys older than girls (see Table 1), reached statistical significance, we examined its possible implications for the sex differences reported in Table 3. It is apparent from inspection that the direction of most of these differences is not what one would expect on the basis of age alone.

<sup>3</sup> For the purpose of simplicity of presentation, these few relationships were not included in Table 4. Overdependent children were slower in being toilet trained and manifested a higher incidence of thumb sucking, and children who engaged in excessive thumb sucking were less defiant. The respective chi-squares for these three relationships were: 3.94, 3.68, and 4.14;  $df=1$ ; corrected for continuity.



and we found that our hypothesis was borne out, namely, separation anxiety did occur least often in boys with the whole cluster of aggression, hyperactivity, and temper tantrums (Mann-Whitney Test:  $p < .10$ ).

We also found in a small group of boys a network of relationships representing the reverse of the low impulse-control syndrome. Boys *with* separation anxiety were overdependent on their parents; overdependence in turn correlated with passive regression, and thumb sucking with compulsive neatness<sup>4</sup> (see Table 4). Passivity and

<sup>4</sup> See examples in Appendix.

TABLE 4  
Chi-Square Tests of Relationships Between Problems  
in 55 Boys and in 55 Girls

	Boys		Girls	
	$X^2*$	$p$	$X^2*$	$p$
<i>Temper Tantrums, with</i>				
Aggression	3.27	$<.10$	.58	$<.50$
General toilet training (slow)	5.28	$<.05$	.84	$<.50$
Frustration tolerance (low)	15.68	$<.01$	3.71	$<.10$
<i>Defiance, with</i>				
Aggression	4.04	$<.05$	.17	$<.70$
Hyperactivity	11.92	$<.01$	.65	$<.50$
Sleep disturbance	4.04	$<.05$	1.65	$<.20$
Separation anxiety	-3.30	$<.10$	1.22	$<.30$
<i>Overdependency, with</i>				
Separation anxiety	3.36	$<.10$	.02	$<.90$
Regression	10.07	$<.01$	.01	$<.95$
<i>Thumb sucking, with</i>				
Compulsivity	4.35	$<.05$	.32	$<.60$
<i>Aggression, with</i>				
Fears	7.68	$<.01$	-.14	$<.80$
<i>Temper Tantrums, with</i>				
Emotional overcontrol	.15	$<.70$	-4.29	$<.05$
Bowel-control problems	.01	$<.95$	-8.09	$<.01$
<i>Separation anxiety, with</i>				
Bowel-control problems	.73	$<.50$	-7.34	$<.01$
Sibling rivalry	.01	$<.95$	7.19	$<.01$
<i>Overdependency, with</i>				
Frustration tolerance (low)	.15	$<.80$	3.80	$<.10$

\*  $df=1$ , corrected for continuity.

compulsiveness point toward repression of and reaction formation against impulse expression. Thus, we find in some of our boys a series of relationships between symptoms which, although less interwoven, represent a pattern of intensive ties to the mother and overcontrol of impulse expression.

Clinical studies have often pointed to a link between separation anxiety and repression of aggression. Such a link may help us to understand the next findings. For example, aggression and fears were positively and highly correlated in boys (see Table 4). This finding raised a question of considerable importance. Are the fears in these boys a reaction to possible consequences of expressing their aggressive impulses, or is their uncontrolled aggression a reaction to fear? Fortunately, we had relevant data that could throw some light on this question by indicating which of these two problems appeared earlier in the development of our boys. As can be seen from a comparison of the first and fourth columns in Table 5, fear was noted earlier than aggression in boys. This finding suggests that aggression is a reaction to fears in the development of these boys. Once this sequence is established, aggression may, of course, in turn lead to fears as well as a general apprehension over the consequences of aggressive impulses and acts.

TABLE 5  
Age of Onset for Problems of Aggression and of Fears

<i>Age Range in Months</i>	<i>Aggression</i>			<i>Fears</i>		
	<i>Boys</i>	<i>Girls</i>	<i>Total</i>	<i>Boys</i>	<i>Girls</i>	<i>Total</i>
	<i>Number of Problems*</i>			<i>Number of Problems**</i>		
	<i>N=24</i>	<i>N=12</i>	<i>N=36</i>	<i>N=15</i>	<i>N=27</i>	<i>N=42</i>
	<i>Cumulated Percentages</i>			<i>Cumulated Percentages</i>		
0-6	4.2	0	2.8	40.0	11.1	21.4
7-12	25.0	16.7	22.2	60.0	18.5	33.3
13-18	50.0	16.7	38.9	73.3	22.2	40.4
19-24	62.5	50.0	58.3	86.6	48.1	88.0
25-36	79.2	75.0	77.7	93.3	85.1	92.8
37-48	95.9	91.7	94.4	93.3	92.5	92.8
48+	100.0	100.0	100.0	100.0	100.0	100.0

\* For 25 problems reported the age of onset was not given.

\*\* For 21 problems reported the age of onset was not given.

It is important to stress that the above findings apply only to boys. Fears did not correlate with and did not appear earlier than aggression in the developmental sequence of girls (see Tables 4 and 5).

Since this patterning and a meaningful interrelated network of symptomatology emerges so consistently in the early life of boys, it would be an important next step of research to investigate how biological and sociocultural factors interact in the development of this syndrome in the male child. Of course, the fact that mothers were the main informants of these data raises important questions. Does this mean that mothers in our sample create this syndrome, or that they are more sensitive to fears in the male than female infant, and less tolerant of or more disturbed by hypermotility and low impulse control in their male children?

When we turn to the patterning of symptoms in girls, we find fewer and more isolated relationships. However, impulse control appears again as a central problem in the patterning of symptoms. While lack of impulse control emerged as a core problem in most boys, overcontrol appeared to be a central problem in most girls. Not only did we find significantly more girls with emotional overcontrol (see Table 3), but girls with this problem had fewer temper tantrums than other girls (see Table 4). Similarly, girls with bowel-retention (overcontrol) problems manifested fewer uncontrolled temper outbursts. This relationship was found only in girls and was the converse of the findings in boys, i.e., boys with slow toilet training tended to have temper tantrums.

The relationship between impulse control and problems in object relations reveals further interesting sex differences. As mentioned earlier, defiance and its related pattern of impulsivity were associated with absence of separation anxiety in boys. By contrast, in girls, overcontrol of impulse expression, i.e., bowel retention, was associated with significantly less separation anxiety (see Table 4). Thus, it may be that girls defy the parent by overcontrol of impulse expression.

The relationship between separation anxiety and impulse control yielded still another sex difference. As reported earlier, boys with separation anxiety manifested fewer aggressive outbursts. Girls with separation anxiety manifested more sibling rivalry which is a more indirect and interpersonal expression of aggression (see Table 4). This suggests that there may be a different link between separation

anxiety and aggression in girls than in boys. It is possible that the closer bond between a girl and her mother contributes to a heightening of separation anxiety in the face of even indirect and milder forms of aggressions such as sibling rivalry. A similar interpretation may apply to the finding that overdependent girls had low frustration tolerance (see Table 4).

When we analyzed the age of onset of the problems of overcontrol and overdependence which appeared more often and were central to the symptom patterning in girls, we did not find that these problems were noted significantly earlier in the development of girls than boys. However, we did have one finding with respect to age of onset which was of particular interest. Thumb sucking was noted earlier in girls than in boys (see Table 6). Thumb sucking also tended to occur more often in our girls, but this sex difference did not reach statistical significance. Honzik and McKee (1959), in a recent comprehensive review of thumb sucking in relation to sex difference, reported that a relatively large number of studies over several decades have reported the same finding, that is, that thumb sucking tends to occur more often in girls than in boys without the difference reaching significance. It is therefore of particular interest that we found thumb sucking to occur not only somewhat more often in girls than in boys, but also earlier. This latter difference again falls short of reaching significance. However, it lends added support to a greater importance of thumb

TABLE 6  
Age of Onset for Problems of Thumb Sucking

<i>Age Range in Months</i>	<i>Boys</i>	<i>Girls</i>	<i>Total</i>
	Number of Problems*		
	<i>N=10</i>	<i>N=14</i>	<i>N=24</i>
	<i>Cumulated Percentages</i>		
0- 6	40.0	71.4	58.3
7-12	40.0	78.5	62.5
13-18	40.0	78.5	62.5
19-24	80.0	92.8	87.5
25-36	100.0	100.0	100.0
37-48	—	—	—
48+	—	—	—

\* Age of onset was not reported for 10 children with problems of thumb sucking.

sucking in girls. A question that arises and needs to be further investigated is whether thumb sucking in girls at this early age, before one year of life, already is so intensive that it attracts the attention of the mother, or whether the mother has less tolerance of this type of oral gratification in the same-sex child than she has in the opposite-sex child.

We can now raise a question in relation to girls similar to the one we have raised in relation to boys. Are mothers more insistent on impulse control in girls, and do they succeed in achieving this control via an exaggerated bond between the girls and themselves? How does this overcontrol of impulse expression, and the associated indirect expression of aggression in early childhood, relate to the position of the woman in the family life of our society?

Finally, in seeking answers to these questions it will be necessary to add at least two steps to further research in this area. First, direct study of the infant and mother-child interaction must be added; and second, reports of the mother's as well as the father's attitudes and observation should be obtained concurrently with those of the child's problems rather than largely via recall or reconstruction.

#### SUMMARY AND CONCLUSIONS

The present study was based on a systematic analysis of emotional disturbances in 110 children of preschool age. The data were obtained from diagnostic interviews with parents of these children at the Child Development Center in New York City. Our essential findings were as follows:

1. There was a wide range in the frequency of disturbances reported. Feeding and sleep disturbances were reported most often and constituted the largest share of early difficulties in the mother-child relationship. Problems of fear and aggression also occurred in more than half of our children. In marked contrast was the low incidence of problems in toilet training and of autoerotic behaviors.

2. Over-all differences were found in the patternings of problems for boys and for girls. (a) Aggression, hyperactivity, and temper tantrums constituted an interrelated cluster of impulsiveness which appeared more often in boys than in girls. This cluster was associated with defiance of parental demands and with an absence of separation anxiety, i.e., of intensive ties to the mother figure. The inverse

relationship between aggression and separation anxiety suggested a lack of repression of aggression in impulsive boys and raised a question concerning the high incidence of fears that we found in aggressive boys. Further analysis of the data revealed that in boys fears were reported developmentally earlier than was aggression. This finding suggested that a heightening, rather than inhibition, of aggression was the more frequent response to fears in these boys. (b) Although there was less patterning of symptoms in girls than in boys, impulse control again emerged as a central difficulty. However, the inter-related problems of girls pointed toward overcontrol and indirect expression of impulses. Our findings suggested a different link between separation anxiety and aggression in boys than in girls. A further interesting sex difference suggested by our data was that boys in our culture tend to express defiance by lack of impulse control, whereas defiance by overcontrol is more common in girls.

We have stressed in the introduction of this paper some of the limitations inherent in research on symptoms in early childhood. In closing, we would like to emphasize what impresses us as a potential contribution which this approach promises. Our procedure of screening clinical data prior to their use in research assured us of a more valid synthesis of quantitative and clinical methods that may well have contributed to the systematic and clinically meaningful findings of our study. Finally, the present investigation, which was essentially empirical and analyzed only data on symptoms, yielded findings which threw light on important questions of etiology and suggested several hypotheses for further study in the psychopathology of early childhood.

## APPENDIX

### *Examples of Symptom Statements by Parents*

#### 1.\* *Feeding*

- a. Still has to be spoon fed, poor eater.
- b. Refuses to eat unless fed like older sibling.
- c. Avoids solids.

\* These numbers correspond with the listing in Table 2.

A number of problems which are not defined were omitted because definition was self-evident, e.g., bladder and bowel disturbances, thumb sucking, nail biting, tics, drooling.

2. *Sleeping*
  - a. Poor sleeper, wakes at night screaming.
  - b. Nightmares, gets up several times at night, moans and cries.
  - c. Night terrors, reluctance to go to bed.
3. *Fears*
  - a. Fear of wind and leaves, sirens, thunder, etc.
  - b. Fears of doctors, witches, clowns, bugs, dogs.
  - c. Fear of being in water, and of the dark.
4. *Aggression*
  - a. Hostility to parents, e.g., spits at them.
  - b. Constant fighting and hostility between child and adult.
  - c. Overly aggressive with children and adults.
5. *Temper Tantrums*
  - a. Throws herself on floor, gets blue.
  - b. Screams and yells and vomits.
6. *Overdependency*
  - a. Clinging.
  - b. Overattached to mother.
  - c. Constantly demanding love and attention.
8. *Speech*
  - a. Occasional stuttering when excited.
  - b. Stutters, can't get words out.
  - c. Refuses to speak, makes vowel but no consonant sounds.
9. *Defiance*
  - a. Disobedient and provocative behavior toward his parents.
  - b. Defiant to mother.
  - c. Defies mother, demanding her to do what she wants.
10. *Frustration Tolerance*
  - a. Lying and upset when frustrated.
  - b. Unable to accept any prohibition against playing with dangerous equipment.
13. *Compulsivity*
  - a. Ritual at bedtimes.
  - b. Dislikes dirtiness; keeps clothes clean and is careful not to drop food on himself.
  - c. Overly neat and prim.
14. *Separation Anxiety*
  - a. Refuses to be separated from mother.
  - b. Clings to mother and does not want to be alone.
15. *Hyperactivity*
  - a. Hyperactive, always has to be doing something; mother could hardly keep him in the crib.
16. *Sibling Rivalry*
  - a. Jealous of younger sister, wants to be fed.

- b. Vomited continuously after birth of sibling.
- c. Always pushes older sister around.
- 17. *Regression*
  - a. Wants to be fed like a baby.
  - b. Wants to be carried instead of walking.
  - c. Asks to be dressed and fed more often after birth of brother.
  - a. No toilet training.
- 18. *Toilet: General*
  - b. Refuses to be toilet trained, fusses when put on potty.
  - c. Not trained; two or three accidents a day.
- 19. *Emotional Overcontrol*
  - a. Extremely repressed, unable to express anger.
  - b. Extreme shyness.
  - c. Unable to express love or joy.
- 21. *Imaginary Figure*
  - a. An imaginary figure called "Haddish" plays a very important role in her life.
  - b. Imagines a child called Bobby and does everything with him.
  - c. Imaginary friends, has a good deal of fantasy life.
- 22. *Sex Identification*
  - a. Wants to be a boy, dress like one, and to be called "John" instead of Susan.
  - b. Wants to urinate like a boy, tries standing up.

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